ADVANCED FOOT CARE CLINIC

Patient Authorization to Use and Disclose
Protected Health Information (PHI)

Patient Name: ___________________________ Patient ID#: _______________

Address: _______________________________ Home Phone: _____________

City/State/Zip: __________________________ Work Phone: ______________

I hereby authorize the above-named Practice (the "Practice") to use and disclose the following Protected Health Information ("PHI"):

The above-described PHI will be released to the following entities:

The entities receiving this PHI may use it for the following purposes:

I understand and acknowledge that:

1. The office will or will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.

2. This authorization is voluntary and I may refuse to agree to its terms without affecting any of my rights to receive health care at the Practice.

3. This Authorization may be revoked at any time by notifying the Practice in writing at the above address to the attention "Privacy Officer."

4. The revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.

5. The information used or disclosed pursuant to this Authorization may be subject to being disclosed again by the recipient and thus this information will no longer be protected by federal privacy regulations.

6. My health care and payment for my healthcare will not be affected if I do not sign this form.

7. I may see and copy the information described in this form, if I ask for it, and that I will get a copy of this form after I sign it.

8. This form was completely filled in before I signed it and I acknowledge that all of my questions were answered to my satisfaction, that I fully understand this authorization form, and have received an executed copy.

9. This authorization is valid as of the date I have signed below and shall remain valid for a period of one [*or some other period*] year.

____________________________ __________________________________
Name of Individual (Printed) Signature of Individual Date

Witness: _______________________